STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57ME	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #22621, CI MS #22694 and CI MS #22929 at the facility from 10/18/23 through 10/20/23. CI MS #22621 was investigated related to Quality of Care, Dietary Services, Resident Rights, Resident Abuse, and Physical Environment, with no deficiencies cited. CI MS #22694 was investigated for Quality of Care and Resident Rights with no deficiencies cited. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500 related to CI MS #22929 for Resident Rights/Abuse with deficiencies cited related to Resident Rights.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		11/28/23

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice,	M 500		

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M 500	Continued From page 2 free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by:	M 500		

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M 500	Continued From page 4 Level II Based on record review, interviews, and facility policy review, the facility failed to ensure residents were treated with respect and dignity for two (2) of five (5) residents reviewed. Residents #2 and #5. Findings include: Record review of the facility policy titled, "Policies and Procedures," with "Subject: Resident Rights," dated 11/30/14, revealed, "It is the policy of The Company to ...1. Ensure that residents' rights are known to staff ...5. Ongoing training on resident rights will be given to staff members as required by state and/or federal regulations ..." Resident #2 Record review of the Facility Investigation dated 9/25/23, and an Incident Report for Resident #2, dated 9/24/23, revealed that Resident #2 had reported to the Director of Nurses (DON) that Certified Nurse Aide (CNA) #3 was "very mean and rude." Record review revealed an attached statement from Resident #2, recorded and signed by the Administrator, dated 9/26/23. In the statement, Resident #2 stated that a few days ago, which was determined to be Sunday, 9/24/23, a CNA was rude and mean to her while providing incontinent care and when asked not to be so rough, the resident stated the CNA did not respond verbally to the request, however, the resident revealed the CNA seemed to get rougher. On 10/18/23 at 10:45 AM, an interview with the Administrator revealed she was made aware of the allegation of mistreatment of Resident #2 by	M 500	Upon notification of the incidents related to Resident #2 involving Certified Nurse Assistant (CNA) (#3) violating the Residents Rights, an assessment was conducted by the Director of Nurses on 9/26/23 with no injuries noted. Upon notification of the incident related to Resident #5 involving Licensed Practical Nurse (LPN) (#1) violating the Residents Rights, an assessment was conducted by the Nurse in charge with no injuries noted. CNA (#3) and LPN (#1) were suspended pending an investigation of the incidents, which resulted in termination of their employment with the facility. Interviews were conducted with residents in the same care group of Resident #2 on 9/26/2023 and with Resident #5 on 10/20/2023. No occurrences of violation of Resident Rights were revealed. Residents on census have the potential to be affected. Staff Education was initiated by the Director of Nursing related to Abuse, Neglect and Reporting Procedures with an emphasis on Residents Rights beginning 9/26/2023 and on 10/20/2023 with all staff to be completed by 11/15/2023. Staff will receive education on Resident Rights upon hire, quarterly and as needed. Social Services will conducted education each month with Residents during Resident Council meeting pertaining to their Resident Rights beginning 11-8-2023.	

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M 500	Continued From page 5 the Director of Nurses (DON) on 9/24/23, and a thorough investigation resulted in the end of the employment of CNA #3. The Administrator described Resident #2 as alert, oriented and well spoken. The Administrator stated that a review of the personnel folder for CNA #3 revealed previous concerns regarding treating residents rudely. On 10/19/23 at 4:20 PM, during a telephone interview with the Resident Representative (RR) for Resident #2, she revealed that the resident had been discharged from the facility due to change a in condition and was unavailable for interview because she was in the Intensive Care Unit (ICU) in a hospital in another state. The RR stated that she was the resident's daughter and that her mother had reported to her that CNA #3 was rude and mean to her during care on or around 9/24/23. The RR stated she was sure the resident was making an accurate allegation because "she (CNA #3) was rude to me too." On 10/19/23 at 6:20 PM, an interview with the DON confirmed that Resident #2 had reported an allegation of disrespectful treatment which resulted in suspension of CNA #3 during a thorough investigation. The DON confirmed that the employment of CNA #3 was terminated as a direct result of the investigation. She stated that the facility conducted an Education In-Service for all facility staff on 9/26/23 titled "Abuse, Neglect and Reporting, Incontinence Care Attitudes" with included instructions and policy and regulation review. The DON stated that all residents should be treated with dignity and respect, and it was against facility policy and current standards of care to treat residents otherwise. On 10/20/23 at 4:55 PM, an interview with the	M 500	The Quality Assurance Committee recommended Quality Review interviews be conducted and documented by Social Services or Charge Nurse beginning 11-3-2023 with (5) Residents daily for (2) weeks, then (5) Residents (3) times weekly for (2) weeks, then (5) Residents (1) times weekly for (2) weeks, then (5) Residents (1) times bi-weekly for (1) month, then monthly for (2) months. Findings revealed in the Quality Review monitoring interviews will be reported to the Quality Assurance Committee for recommendations on 11/27/2023 for 4 months.	

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M 500	Continued From page 6 Administrator revealed that she stated that the facility had provided in-service training for all staff on 9/26/23 regarding Resident Rights and treating residents with respect and dignity, following an incident with Resident #2. Record review of the "Admission Record" revealed Resident #2 was admitted to the facility on 9/19/23 with diagnoses that included Hemiplegia and Hemiparesis, Acute Myocardial Infarction and Congestive Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/26/23 revealed a Brief Interview for Mental Status Score (BIMS) of 15 indicating Resident #2 was cognitively intact. Resident #5 On 10/18/23 at 12:30 PM, during an interview with Resident #5, the resident reported that last night, the resident was not sure of the time, he had slid out of his bed and that when his CNA (he did not know the CNA's name) had entered his room, she had yelled at him to "get up". He reported that when the CNA realized that he was unable to get up without assistance, she summoned the nurse and they had assisted him back into bed and left him lying in bed, "like a sack of potatoes." Resident #5 said he had to scoot himself around to get positioned in his bed. Resident #5 revealed that being yelled at and left that way in bed, left him feeling undignified. Resident #5 described his treatment by the CNA as "mean and hateful". On 10/18/23 at 12:45 PM, in an interview with the Resident #5's roommate, an unsampled resident,	M 500		

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M 500	Continued From page 7	M 500		

he revealed that last night he woke up and saw Resident #5 on the floor. The resident stated he was unsure of the time, but realized it was still dark outside. Resident #5's roommate said the CNA who came into the room (he did not know her name) was rude and hollered at Resident #5 to "get up." Resident #5's roommate stated that he told the CNA "He can't get up, you got to help him." Resident #5's roommate commented that after they got Resident #5 back in bed, they just left him and confirmed that he saw Resident #5 moving himself around in the bed, trying to get straight.

On 10/19/23 at 5:00 PM, an interview with the Administrator revealed she was not aware that Resident #5 had been found on the floor or that there was an allegation of disrespect or undignified treatment. She stated that the incident should have been reported to her. She stated all incidents involving falls are reviewed by the interdisciplinary team.

On 10/19/23 at 6:05 PM, an interview with Registered Nurse (RN) #1 revealed she was the RN Supervisor for the building and usually worked 8:00 AM to 4:30 PM every Monday through Friday. She stated that all incidents, including falls, were supposed to be documented by nurses and are reviewed every morning by the interdisciplinary team during their morning meeting. She stated that there had been no reported fall or allegation of mistreatment regarding Resident #5 recorded by the nursing staff on the night of 10/17/23 or predawn hours of 10/18/23. RN #1 stated that when a resident is found on the floor, it is considered a fall, and an incident report should have been done. RN #1 stated that the roommate of Resident #5 had reported an incident of a fall involving Resident #5

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M 500	Continued From page 8	M 500		

and disrespectful treatment by staff during Resident #5's care, on 10/19/23 at approximately 6:00 PM.

On 10/19/23 at 6:17 PM, a telephone interview with Licensed Practical Nurse (LPN) #1 revealed that Resident #5 had been located on the floor of his room next to his bed during the predawn hours of 10/18/23. LPN #1 stated that she had been summoned to Resident #5's room by CNA #4 and observed Resident #5 sitting on the floor next to his bed. She stated that she and the CNA #4 assisted the resident to transfer back into his bed. She stated that she could not remember if she documented any progress notes, filled out an incident report, or completed any documentation of the fall. She stated she did not notify the primary physician or the resident's RR, as the resident had stated that he slid out of bed and denied any injuries. She stated she had reported the fall to the oncoming shift during the shift change report.

On 10/19/23 at 6:20 PM, She stated she was not aware that Resident #5 had voiced an allegation of being treated with lack of respect or that he had had a fall during the nighttime hours of 10/17/23 or predawn hours of 10/18/23. She said that Resident #5 had a condition which she observed as progressing recently, leaving him weaker and less able to assist with transfers. She stated that she thought it would have been disrespectful for staff to ask to instruct the resident to do things he was not physically able to do or to leave the resident without repositioning in bed, following a floor to bed transfer.

On 10/19/23 at 6:30 PM, during a telephone interview with CNA #4, the CNA confirmed she had observed Resident #5 sitting on the floor next

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to his bed in his room during the predawn hours of 10/18/23 and summoned LPN #1 to the resident's room for assistance. CNA #4 stated that she kept telling him to use his legs, but he wouldn't, so she scooped his legs up onto the bed. CAN#4 commented that everything they asked him to do he, he wouldn't. CNA #4 confirmed that Resident #5 stated that he couldn't help. She confirmed that Resident #5 was not repositioned after he was assisted back into his bed. CNA #4 stated, "I didn't know what was wrong with him, it was never explained to me." CNA #4 did state that care instructions for each resident was available to all CNAs "on the kiosk (computer with software for documenting care)."

On 10/20/23 at 4:55 PM, an interview with the Administrator confirmed that at least three staff members had been aware of the incident which occurred in the predawn hours of 10/18/23, during which Resident #5 was observed on the floor of his room. She confirmed that "yelling" or "hollering" at a vulnerable resident on the floor to "get up" or "use his legs" and that leaving the resident without repositioning him in bed did not provide the resident with respectful or dignified care. She stated, "We are going to just keep working on it."

Record review of the "Admission Record" revealed Resident #5 was admitted to the facility on 7/7/22 with diagnoses that included Unsteadiness on feet, Other lack of coordination and Generalized anxiety disorder.

Record review of the MDS with an ARD of 8/24/23 revealed a BIMS score of 14 indicating Resident #5 was cognitively intact.